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Geri Amori, PhD, ARM, DFASHRM, CPHRM: Hello, everyone, and welcome to *Healthcare Perspectives 360*, a podcast dedicated to exploring contemporary healthcare issues from multiple perspectives. I'm Geri Amori, and today I am joined by Samantha Chao, MD, HEC-C, Director of Emergency Medicine Ethics and Clinical Assistant Professor in the Department of Emergency Medicine at Michigan Medicine. She is a certified clinical ethicist. She completed medical school, residency training, and both pre and postdoctoral ethics fellowships at the University of Michigan. She is also a member of both the ACEP and SAEM Ethics Committees.

We also have Saulius D. Polteraitis, Esq., a principal at Nauts, McKinney, Dwaihy and Beach, specializing in medical malpractice defense. Mr. Polteraitis has worked with various hospital systems and physicians groups throughout the state of Michigan defending medical malpractice claims.

We also have John Dery, DO, and he has multiple board certifications in emergency medicine. He is an Associate Professor of Emergency Medicine at Michigan State University School of Human Medicine in East Lansing, Michigan, and has been in clinical practice for over 14 years. Dr. Dery continues to make changes at both national levels, where he currently serves on the executive board of directors of the American College of Osteopathic Emergency Physicians and locally in his community as a sworn law enforcement officer.

Joann Wortham, RN, MSN, JD, CPHQ, CPPS, CPHRM is a seasoned international thought leader who uses insight from lived experiences, along with her background in education, healthcare, business, and risk management to create novel approaches to today's most critical workplace concerns. Welcome to our panelists.

Today we're talking about the ways that healthcare organizations should be prepared to manage the presence and demands of law enforcement in healthcare. Those of us who have worked around healthcare will know that policies and procedures to guide staff, providers, and administration in how to manage the myriads of complex situations that are faced daily are key. This is clearly true in those situations where healthcare that focuses on healing, protecting, and providing care meets law enforcement and the primary mission and values for protection of the general population from criminal activities and harm.

In some ways, these two missions are like oil and water, the values and health of the individual versus prosecution of crime and societal protection. But we have had some discussions about the ethical dilemma raised by these competing interests of law and the rights of patients, regardless of their legal status, as well as the psychological safety of staff and visitors. So today, we are going to discuss the pragmatic preparation that healthcare organizations should take to ensure they have plans in place to address these situations. What should those policies and procedures address so that healthcare organizations are prepared to manage the unanticipated presence of law enforcement officers in the office, ED, or on the medical floor.

So, I'm going to start with our lawyer, Saulius, as the lawyer on our panel. I'd like to start with you. Given that the federal laws which govern healthcare, like HIPAA and EMTALA, and the rights of

patients who are not under arrest or detention to decline speaking with law enforcement, what types of procedures should both inpatient and outpatient healthcare sites have in place?

Saulius Polteraitis: Well, due to differences in demographics or geography, staffing, or the relative healthcare services provided, there are no hard and fast rules about what policies need to be in place. And of course, each hospital and facility is likely to be confronted with different situations and unique obstacles. Now, hospitals are often expected to take steps to ensure psychological safety for both the staff and visitors and patients, and there's multiple legal frameworks for that. You have OSHA, which requires employers to provide a workplace free from recognized hazards, that could be interpreted to include psychological hazards. That is usually like a general duty clause. It's not necessarily specific to workplace violence. However, in 2016, OSHA did issue guidelines for workplace violence prevention for healthcare and social service workers, but that typically was more advisory in nature.

Also you have joint commission standards that mandates the facilities address workplace violence and foster a culture of safety. In fact, they updated those standards in 2022. And then finally, you are going to have state laws and licensing requirements, and a lot of states require hospitals to have workplace violence prevention programs. There are some laws that are kind of pending. I know that there was one about workplace violence prevention for Health Care and Social Services Act. It passed the House of Representatives in 2021. It's obviously still languishing and hasn't passed the Senate. But there are definitely legal grounds for hospitals and healthcare facilities to protect the psychological safety of, again, the visitors, patients, and the staff.

Amori: Okay, thank you. That's really, really important. John, what kinds of structures and policies do you think need to be in place that provide guidelines for when officers may remain at the bedside, for example, when they are guarding a detainee versus observing a patient? And for whether and when they can carry firearms in sensitive areas, like – I don't know – ICUs, ED resuscitation rooms, or psychiatric units.

John Dery, DO, FACOEP-Dist, FACEP, FAWM: Great question. When I'm in a role as a law enforcement officer, it depends on the situation, and it defaults to what my department or agency's standard operating procedures are going to be. Those are the constraints that I'm working under at that time. If I am operating under the premise of being law enforcement, I am to remain armed. I have to be able to protect myself, protect the public as my primary duty and responsibility. Some hospitals might have a problem with that, and at that point, any situation, deescalate anything. So to talk to a department supervisor. I would make sure I get my supervisor. That’s the joy of being an underling in the law enforcement side, I always have a supervisor that can tell me what to do or can tell somebody else what to do.

I could ask the facility to provide an escort, if possible. At the end of the day, it provides an opportunity for the law enforcement side and the hospital or outpatient clinic side to have some education, opportunities for learning, opportunities to find out what we want to do in these situations. Maybe it's providing a weapons lockbox. I will never surrender my sidearm to a civilian or somebody else. I mean, I have to be able to protect myself at all times, protect others, that's my primary role in that capacity.

But if I am going to be unarmed, it has to be done in a proper way that my weapon is secured with the proper people or in my vehicle. But that will be very unlikely. Anytime you're wearing a badge, you

have a target on your back. There's a lot of attacks that have been perpetuated in today's society and climate against officers on and off duty at any given time. It is very hard to try and get an officer to surrender their weapon, in general.

Amori: Yeah, I can understand that. I think I'd be afraid to. Joann, how do we ensure that staff have clarity about who to contact and who has the responsibility in the healthcare organization when disputes between staff and law enforcement officers arise?

Joann Wortham-Moody, RN, DNP, JD: I think that's such a critical question. Because when a law enforcement officer is standing at the front desk demanding information or access, that's not the time to be figuring out who's in charge. So staff need that clarity long before an incident actually happens. So from a risk management and an operational readiness perspective, if you will, again, I'm going back to, you know, what risk managers do, and what we're always preaching about is policy, policy, policy. That law enforcement interaction policy every organization should have it.

And first, let's just talk about the three things it should include. First, it should clearly define roles and escalation pathways, like who's authorized to speak with law enforcement, who can release the information, and who needs to be contacted immediately. We really need to have some type of escalation chain within those policies. Should they be contacting the privacy officer, the risk manager, compliance officer, administrator on duty, who is it? Second, we have to train staff regularly using real-world scenarios. I am a proponent of theater-based learning. So that our medical assistants, the front desk clerk, the nurse, all of them know exactly what to do, because they've been included in the training, and they train together. We train our code team together so that everybody will know what their role is.

I'm always saying bring stakeholders together for these same type of scenarios, so that everyone will know what their role is. A simple script giving them scripting like we do when we go and train for CPR. Hey, are you okay? Are you okay? Like everybody knows what the script is. So we can teach them scripting for these particular incidents also. So let me contact our privacy officer. We'll be right with you in just a moment, sir. All that scripting actually helps.

And then lastly, leadership has to reinforce that this is not optional. Employees should never feel like they're being insubordinate or obstructive for pausing to verify the law. And that these people actually are supposed to be there and actually need to be on premises, or that they have the ability or lawfully have the ability to receive this information. So just being very clear. Clarity starts with our policy and our procedure and our educating our staff on those policies and procedures.

Amori: Okay, thank you, Joann. Sam, I have a question for you, but I hear you have a comment too. I see that. What would you like to say?

Samantha Chao, MD, HEC-C: I would say, you know, I am definitely a person who, like is a proponent of hospital policies need to exist and need to be relevant to providers who are giving care at the bedside. But it's really interesting, because it's like you hear Joann talk about hospital policy. You hear Dr. Dery talk about procedures and policy from the law enforcement side. And really what the problem is is those policies don't talk to each other. And so the fundamental problem is that when law enforcement enters the healthcare space, it is unclear whose policies and procedures are going to take precedent or are going to take more authority.

And so, I think an idealized world is a collaborative approach where you are involving both law enforcement leadership and hospital leadership to decide in these situations, how are we collaboratively going to work to care for these patients. Because I've seen it happen so much like regardless of what hospital policy I have, I will always be faced with an officer who says, well my internal protocol dictates otherwise, or I have hospital policy that says you need to defer to law enforcement in this situation, even when I think it's inappropriate.

Wortham-Moody: Can I have something to say to that, Geri? Can I say one thing?

Amori: Sure. But I have John chopping at the bit. He wants to say something. Let's let him chop at the bit. Then we'll come back to you. Come on, John.

Dery: Oh, just real quick, I always like to diffuse everything with humor. So I would always say, if I didn't have my sidearm, I'm not much useful. I can't really protect anybody with my sharp wit and good looks.

Amori: Okay, all right. So what would you like to add to that, Joann, that's hard to top?

Wortham-Moody: That is hard to top. But I want to just say one thing about an experience that I had. We included the police chief. When we had an issue with nurses not wanting to draw blood for the particular folks in custody that they were bringing in, and we had police officers getting angry with nurses and angry with doctors in the emergency room. So we called the police chief over to the hospital, and we made that policy together. And so I agree totally with what was said is that we worked with the community – hand-in-hand stakeholders – to come together to talk about what those policies should be, so that the nurses will not be angry and feel put out and neither would the police officers. And we have a joint policy.

Amori: Okay. And I want to go back to John too. I want to add to that, you know, since you're talking about your good looks and your wit here, should the healthcare organization have unique policies that kind of distinguish when a law enforcement officer is there on duty versus when they're there, say, as a friend or family member? I mean, how do they keep people in their lane?

Dery: Right. If I'm there in uniform, it should be an expectation of I'll conduct myself as I'm representing my department and the agency in which I'm working. And if I am there in plain clothes but still have my badge and perhaps my concealed carryon in an official role, it should be the exact same. The standard should be the same. It shouldn't change situationally, contextually whatsoever. I'm there on their property. I am in my role. I will have to behave myself in a professional, courteous role, just as I would if I was wearing a normal uniform.

Amori: Okay. And Sam, what do you think the chain of command should be in the healthcare organization when clinical staff feel the ethical rights of patients are compromised or threatened?

Chao: I think if they feel that the ethical rights of a patient are being compromised or there is something unethical happening in terms of the patient's care, I think having a task force or like a list of different people – like Saulius was talking about earlier – is really helpful, because they can help in different

ways. So like at our institution, our security force is actually a really helpful intermediary between us and law enforcement, because our security is trained in, like, you know, our certain obligations, as healthcare providers, that maybe the average law enforcement person would not be aware of and then can help serve to be a liaison between us. But also having folks like our ethics consult service available, our office of general counsel, which is our legal team, and also risk management available, I think, are all appropriate people to activate if somebody feels like a patient's care is being compromised.

Amori: Okay. So Saulius, I'm going to get you to put the final word in. But before I do that, I want to ask Joann real quick, real quickly, what kinds of deescalation protocols and trainings do you believe healthcare organizations should have?

Wortham-Moody: It has to be hands on. Really quickly, Geri, it has to be hands on. We have been watching videos until we are dying of I don't know is that a disease, videoism. I don't know what it is. But we have just been watching videos. And it works out so much better when you get the human beings in a room and put the human beings through scenarios, so that the human beings can actually learn how to act through the emotions. Have the emotions and act through the emotions. We do it all the time. We train police officers like that. We train our firefighters like that, our code team, our nurses. And so we need to do the same thing with some of these scenarios is we need to train using active scenario training, theater-based training.

Amori: Hear, hear, I agree with that. Hey, Saulius, do you agree with all that's being said above, or is there something that you feel needs to be said? Like, is there any time the healthcare organization should just capitulate and say, the heck with it, we'll do whatever they want?

Polteraitis: Well, first of all, I believe the panelists all have provided fantastic perspectives. And I don't know if I would use the word capitulate – I mean because that, you know, by definition, means give up – and I don't think we should give up. I think what these episodes that we've gone through have highlighted are instances when standing up for patients' rights, you know, has really affected significant change. Now, obviously there are times where law enforcement meets all the requirements under the law, and there are times where there are no ethical obstacles or conscientious objections, and then the healthcare organizations can see to the request.

But I'm still reminded of the body cavity case, you know, back in August of 2024, where the physicians refused to conduct this body cavity search on a patient, even when presented with a warrant, And they had, you know, both medical and ethical reasons for doing so. What made that story so significant was the escalation. The police chief calls the head of the hospital threatening to arrest him for violating a warrant. You know, the prosecutors file criminal contempt charges. And then you have the hospital then suing, you know, the state. But what ends up happening – and what we've kind of been talking about here – is that both of these two worlds kind of come together, and then what ends up happening is they come to an agreement.

They drop the lawsuit. The charges get dropped. The police department ends up agreeing to finally provide the security services. And what they end up doing is creating a new policy regarding these body cavity searches so that both of them agree upon. So what I think a story like that does is it informs and inspires other healthcare facilities, other healthcare providers, to follow their moral compass and work within the bounds of ethical and legal authority to kind of come to the best solution.

Amori: Okay, but it's a lot to digest. You know, we've come to the part of our discussion that is always my favorite part. If you have three sentences – or two – to give our listeners one nugget about this, about how to best be prepared, what would that be? So I'm going to start with you, Joann.

Wortham-Moody: I would say ultimately that under this particular circumstance, teaching our staff that calm is contagious and that it actually helps us to get through most of the things that we're talking about right now, to actually think things through. And so modeling that calm, we actually protect our patients, our colleagues, and ourselves. You know, as all these different things are happening to us, and as we see workplace violence just increasing as we move through this journey of ours through healthcare is that we stay calm and we really think things through so that we can keep ourselves, our patients, our colleagues, and our visitors safe.

Amori: Okay. All right. And Saulius, what would you like to say to end this?

Polteraitis: I think the one big takeaway is train your staff to become familiar with the hospital policies, those are going to guide the ethical decisions. And with that education, not only are you going to create a staff that's going to be more confident in its role and more confident in interacting with law enforcement, but it also will just create a stronger culture of safety and violence prevention for patients, visitors, and staff.

Amori: Okay, all right. And John, what would be your final comments?

Dery: To all of my law enforcement brothers – and sisters – I always say, you never know what someone else's experience is. So just because I know I feel comfortable in that capacity doesn't mean that they might not find me threatening. Carrying a firearm in a hospital demands discipline, to embody protection without any type of provocation, and to be visibly prepared yet never threatening. It's all about honoring the sanctity of the healing environment in the hospital that we're in while remaining ready to defend those that are within it.

Amori: Okay, thank you. And Sam, final words of wisdom.

Chao: I would say my takeaway has more to do with how you develop policy and what kind of policies you should develop. That it's ideal that you have a policy that is developed collaboratively with relevant stakeholders, but that are recognized both by hospital staff and also by law enforcement when it comes to situations in which you need to call upon the policy. And also having ones that are based in real issues that people encounter at the bedside. So that way you can actually help providers navigating these situations, because they come up all the time.

Amori: All right. And with those words of wisdom, I'd like to thank our amazing panelists. This has been an incredibly rich discussion, and it's been wonderful working with all of you. And I'd like to thank our audience for listening. So thank you, one and all, and this closes *Perspectives 360*.

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